New and Revised Operational Guidelines as presented on March 18, 2021 and April 12, 2021

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1.2. Waiting List

1.2.a. Criteria for Determining Eligibility and Placement on the Waiting List

Responsible Office: Regional Community Services
Reference: Administrative Code 580-5-30-.14, Eligibility and Level of Care Determinations for Medicaid Waiver Programs
Revised: March 26, 2021

Statement: Eligibility for Waiver services and placement on the Waiting List will be determined based on verifiable and valid documentation.
Purpose/Intent: The process for determining eligibility for Waiver services and being placed on the Waiting List involves specific, crucial steps governed by detailed standards and practices of communication between the Waiting List Coordinator and the Support Coordination agency.
Scope: Director of Community Programs; Regional Community Services; Support Coordinators
Definitions: DDD IMS (Division of Developmental Disabilities Information Management System); ICAP (Inventory for Client and Agency Planning)
Procedures:

1. The Waiting List Coordinator reviews eligibility documentation in the application packet provided via web-based application by the designated Support Coordination agency, which must include:
   a. A qualifying psychological evaluation administered/interpreted by a qualified professional on/after the eighteenth birthday (for an adult) or within three years of the date of application (for a child less than eighteen years of age).
   b. For a person eighteen years of age or older, another qualifying psychological evaluation prior to the eighteenth birthday.
   c. An ICAP Compuscore report completed within ninety days of the date of a complete application packet.
2. In order for the applicant to be deemed eligible for Waiver services and, thus, placement on the Waiting List, the submitted eligibility documents must unequivocally demonstrate the following:
   a. The applicant evidences significant problems in at least three adaptive functioning subscales (Self-Care, Receptive & Expressive Language, Mobility, Self-Direction, and Capacity for Independent Living and Learning), determined as follows:
      - Self-Care: ICAP Personal Living Domain score < 509 for persons aged 17 or older (reduced cut-off score for younger persons), or (for ages > 4) ICAP Arm/Hand Use item includes 'Some daily activities limited' or 'Most daily activities limited'.
      - Receptive & Expressive Language: ICAP Social/Communication Domain score < 515 for persons aged 17 or older (reduced cut-off score for younger persons), or (for ages > 4) ICAP Communication item includes 'None' or 'Gestures' or 'Sign language or finger spelling' or 'Communication board or device'.
      - Mobility: As determined by responses selected for items 9a and 9b of the Eligibility Assessment, with regard to ability to walk independently and any assistance/assistive devices needed.
      - Self-Direction: ICAP Community Living Domain score < 514 for persons aged 17 or older (reduced cut-off score for younger persons), or ICAP General Maladaptive Behavior includes 'Marginal Problems', 'Moderate Problems' or 'Very Serious Problems'.
      - Capacity for Independent Living: ICAP Broad Independence Domain score < 510 for persons aged 17 or older (reduced cut-off score for younger persons).
      - Learning: As determined from the Diagnosis Record.
   b. The applicant achieved a full-scale IQ score below 70, with no evaluations documenting a full-scale IQ score of 70 or above on an accepted intellectual assessment. The highest score of any evaluation administered will be the score considered as valid.
   c. Onset of the applicant's intellectual disability occurred before the age of eighteen.
   d. The primary cause(s) of impaired functioning or the full-scale IQ less than 70 is not the result of mental illness or external factors such as medication or stress.

3. In the event the application packet does not include any of the documentation listed in 1., above, or does not unequivocally demonstrate that the person meets the eligibility criteria listed in 2., above, the application packet will be considered incomplete, and the Waiting List Coordinator will communicate via DDD IMS to the Support Coordination agency details on which document(s) and/or information (if any) are needed to complete the packet and make a determination on eligibility.
    a. In the event the needed document(s) and/or information are not submitted within 60 days of the Waiting List Coordinator's DDD IMS notification, the application packet will be deemed incomplete, and the Waiting List Coordinator will send to the applicant a Notice of Incomplete Application (found in the Enrollments record in the DDD IMS). A copy of this notification will be recorded in the DDD IMS.
    b. If the applicant has conflicting documentation or has an IQ of over 65 or is hospitalized at the time of application or presents with multiple diagnosis. The CSD will request that the application be reviewed by the Behavioral and Psychological Evaluators from at least three Regional Offices, who will provide a written summary of their recommendation of eligibility within 45 days of receipt of request for review.
4. The Waiting List Coordinator reviews the eligibility question in the Alabama Wait List Application Report in the DDD IMS record.
    a. If the answer to the pertinent eligibility question is "Yes", the Waiting List Coordinator will proceed, as outlined in 6., below.
    b. If the answer to the pertinent eligibility question is "No", the Waiting List Coordinator will review the Eligibility Assessment and the Diagnosis Record to determine data needed to support eligibility and will request any necessary substantiating documentation from the Support Coordinator via the DDD IMS.
    c. The Waiting List Coordinator will only designate the Wait List record as "Approved" when the response to the pertinent eligibility question is substantiated by data on-hand to be "Yes".
5. In the event the applicant is deemed ineligible for Waiver services, the Waiting List Coordinator will send to the applicant a Wait List Denial Notification (found in the Enrollments record in the web-based application), which includes full details on appeal rights and processes. A copy of this notification will be recorded in the DDD IMS.
6. When all necessary documents are received and contain the required eligibility information, and within ninety days of the date of a complete application packet, the Waiting List Coordinator reviews the criticality assessment, completed by the Service Coordination agency to ensure:
    a. All fields are completed fully and accurately.
    b. Each service group is selected under only one needs Category.
    c. Substantiating documentation is provided via DDD IMS, if Category 1 (High Risk) is selected for any service group.
7. Once eligibility is positively determined, and the criticality assessment is reviewed and completed, the Waiver Coordinator will designate the person's Wait List record in the DDD IMS as Approved, thus placing them on the Waiting List.
8. Upon approval for the Waiting List, the Waiting List Coordinator will send to the applicant an Initial Eligibility Notification Letter. A copy of this notification will be recorded in the DDD IMS.

4.2. Request for Action/Services

Responsible Office: System Management
Reference: ADMH/DDD Operational Procedures
Revised: March 5, 2021

Statement: Following a team meeting where all appropriate persons attend, ADMH/DDD requires the support coordinator to submit the **REQUEST FOR ACTION** (RFA) form to the Regional Office Community Service Director or Designee for any addition to a Plan of Care for the following services. The Regional Office should make the determination within no more than **seven (7) working days** to expedite service delivery.

1) Assistive Technology
2) Environmental Accessibility Adaptations (EAA)
3) Specialized Staffing (SS)*
4) Positive Behavior Supports (PBS)
5) Support Services not included in the most recent Person-Centered Plan
6) Changes in staffing levels for participant in Residential Services
7) Increases in the original units authorized for any service
8) Increases over 12 hours per day for personal care
9) Any service not included on the Person-Centered Plan or on the Plan of Care (Day Habilitation, Community Experience, OT, PT, ST, Employment Support, etc.)
10) All Self-Directed changes

Purpose/Intent: To expedite the RFA process
Scope: ADMH-DDD Central/Regional Offices, Support Coordinator Services
Definitions: RFA (Request for Action) - Additions to an individual's plan of care; DDD IMS (Division of Developmental Disabilities Information Management System)

PROCEDURES FOR SUPPORT COORDINATOR

1) Hold a team meeting of appropriate persons; obtain signatures on revised plan of care.
2) Check Medicaid State Plan Services (SPS) and other insurance to ensure an item is not covered
3) Obtain required supporting documentation as necessary (prescriptions, medical documentation, quote, ICAP, etc.)
4) Complete the RFA Form with a detailed assessment (formal or informal) that supports this request
5) Submit the RFA Form to the Regional Office electronically through ADIDIS
   a. Include medical documentation
   b. Quote for service
6) Add service to the plan of care using the following format:
   a. Provider Name
   b. Service Code
   c. Service Name
   d. Unit
   e. Unit Type
   f. Cost
   g. Start Date
   h. End Date
7) Submit RFA form to the Regional Office through ADIDIS

PROCEDURES FOR REGIONAL OFFICE

1) Verify all information is included on the RFA. If not, return to support coordinator with a note in the ***NEEDED INFORMATION*** section of the form. Include the date returned to the support coordinator.
2) Verify the documentation supports the need for service
3) Approved; generate letter to the participant with a copy to the Support coordinator
4) Denied; generate letter to the participant accompanied by appeal rights with a copy to the Support coordinator
5) Sign and date the form and add dates to Plan of Care
6) Mail original letter to participant, copy support coordinator (upload in ADIDIS), copy provider (via email), and copy the Executive Director of the case management agency
7) Copy to Fiscal Officer in the Regional Office to authorize service through ADIDIS

****The provider must submit to the regional office CSD information that all staff providing Specialized Staffing, either medical and/or behavior, has met the training requirements as outlined in the waiver document. When changes in staff occur, the provider must submit to the Regional Office that the new employee has been trained and is qualified to provide the service as outlined in the waiver documents.***

****Services cannot be initiated without an approved RFA.***

An RFA ***is not*** required for in the following situations. A team meeting ***is not*** required in these instances. The process should be ***completed*** in no less than five (5) days to ensure timely delivery of services:

1) Unit currently authorized and on the Plan of Care that require a change.
2) Service documented as an anticipated service in the participant's Person-Centered Plan.
3) All address changes in residential providers or provider sites.
4) Change in providers.

PROCEDURES FOR SUPPORT COORDINATOR

Ensure documentation is evident in the Person-Centered Plan or is **on the Plan of Care and authorized.**

1) Make changes to the participant's Plan of Care
   a. Include the End Date for the previous units and begin date for the new services
   b. Place new service on the participant's plan of care including start and end date using the same format as above
2) Submit note into ADIDIS with copy to the Waiver Coordinator marked ***Alert***.
3) Waiver Coordinator will verify the Plan of Care has been updated; if not, return to support coordinator to correct.
4) Once approved by Waiver Coordinator, mark the note as ***Complete*** copying the support coordinator and the Fiscal Officer.
5) The Fiscal Officer authorizes the service.
6) Support coordinator will notify the provider of the start date of service.

6.3.b. Promotion and Protection of Individual Rights

Responsible Office: Quality Management
Reference: Administrative Code 580-5-30, 580-3-26, Home and Community Based Services Settings (HCBS) Rule
Effective: October 1, 2020

Statement: This process is to guide certification staff in assessing community provider compliance with providing quality supports in the area of individual rights.
Purpose/Intent: To provide a process that ensures the provider practices sound management providing quality services to individuals.
Scope: DDD Waiver HCBS Providers; Support Coordinator Services
Definitions: Home and Community Based Services (HCBS) Settings Rule - The Centers for Medicare and Medicaid Services (CMS) issued the HCBS Settings Rule to require that every state ensure services delivered to people with disabilities living in the community meet minimum standards for integration, access, to community life, choice, autonomy, and other important protections.
Procedures:

A. The Organization implements Policies and Procedures That Clearly Define Its Commitment to and Addresses the Promotion and Protection of Individual Rights of Individuals.

1. The policy lists rights afforded all citizens as indicated by the (US) Constitution, laws of the country, and the State of Alabama.
2. The policies and procedures describe the organization's due process.
3. The policies and procedures for due process include individual rights review and documentation in the event of a proposed restriction of an individual's rights.
4. The organization refrains from having standing policies and procedures that restrict an individual's rights without due process.

B. The Organization Informs People of Their Rights.

1. The organization documents verification that it provides to individuals and their legally authorized representatives an oral and written summary of their rights/responsibilities and how to exercise them upon admission and annually thereafter.
2. The information (in line 1 above) is provided in a format that is in language and style that is easily understood by the individual.

C. The Organization Supports People to Exercise Their Rights and Responsibilities.

1. The organization assesses each individual's ability to understand and exercise his or her rights on an ongoing basis but at least annually
2. The rights assessment addresses individual's civil and legal rights and individual freedoms. The assessment includes but is not limited to the ability to do the following-
    a. Exercise freedom of movement with physical environments, including units with lockable entrance doors, with individuals served and only appropriate staff having keys and will be documented in the person-centered plan, if more than one bedroom, each bedroom should be considered a unit and the "tenant" should have a key to their lockable door. This rule applies to Home and Community-Based Services (HCBS) and settings
    b. Have a lease, residency agreement or other form of written agreement in place that provides protections, and addresses eviction processes and appeals comparable to those provided under the state's landlord tenant law.
    c. Manage money
    d. Send and receive mail including a private place to read and open mail.

e. Privacy to make and receive phone calls and use other means of communication.

f. Have visitors of their choosing at any time. Any restriction of visitors or visitations of the individual's choice must be based on individualized, assessed that is documented in the person-centered plan along with what efforts that will be taken to try to reduce or move the restricted access as soon as may be feasible. This rule applies to Home and Community-Based Services (HCBS) and settings.

g. Access individual possessions.

h. Vote and otherwise participate in the political process.

i. Make choices about religious affiliation and participation.

j. Interact socially with members of either gender.

k. Privacy including a choice of private bedroom or choice of a roommate with furnishings positioned to maximize privacy.

l. Freedom and support to control schedules and activities. This rule applies to Home and Community-Based Services (HCBS) and settings.

3. The rights assessment addresses the need for and scope of advocacy, guardianship and alternatives for each person.
4. Rights assessment results, including supports needed to protect and promote the individual's rights, are documented in the individual's record.
5. The organization provides assistance to the person in areas identified as important by the individual and that individual's support team.
6. The organization provides education regarding voter registration and the voting process to anyone age 18 or over that expresses an interest.
7. The organization assists individuals with voting as needed. (Note: this is not applicable for individuals deemed incompetent due to Alabama voting laws.)
8. The organization provides individualized supports/services that are free from discrimination (race, gender, age, language, ethnicity, disability, religion, sexual orientation, or financial circumstances.)
9. The organization obtains written, informed consent (from the individual) prior to any intrusive medical or behavioral intervention, and prior to participation in research.
10. The consent contains information regarding procedures to be followed, expected benefits of participation, and the potential discomforts and/or risks.
11. The consent information is presented in a non-threatening environment and explained in a language that the individual can understand, and the individual is also informed that they may withhold or withdraw consent at any time.
12. The organization shares information about individuals only with their written, informed consent or that of their legally authorized representative.

D. Decision-making Supports Are Provided to People as Needed.

1. The organization refrains from presuming incompetence or denying individuals' rights to manage financial or personal affairs or exercise other rights solely by reason of his/her having received support services, unless legally determined otherwise.
2. Unless a legal determination of incompetence to participate in one or all of the following activities has been made, every individual is free to access courts, attorneys and administrative procedures, execute instruments, dispose of property, marry and divorce or participate in activities requiring legal representation, make choices regarding services and supports and who provides then without fear of reprisal, interference, or coercion. The individual is informed of all setting options including non-disability specific settings and an option for a private room in their

setting. This information is documented in the person-centered plan.

3. Individuals receive only the level of support needed to make their own decisions. Supports include assisting individuals to advocate for themselves.
4. Each individual has a written plan to obtain advocacy, guardianship and alternatives to guardianship if those supports are needed. Support Coordination and Provider Organizations shall not serve in a guardianship capacity to those individuals that they directly or indirectly support.

E. Staff Are Trained to Recognize and Honor People's Rights.

1. Staff are trained to recognize and demonstrate respect for individuals' rights including how individuals choose to exercise their rights.
2. Staff that complete rights assessments are trained to:
   a. Understand and support individuals' preferences in regard to rights,
   b. To identify goals related to exercising their rights and to support attainment of those goals
3. Staff are trained in due process procedures.
4. Staff are trained in any procedures for placing a limitation or restriction on an individual's rights.

F. The Organization Upholds Due Process Requirements.

1. The organization's due process is defined as providing individuals supported, and their legally authorized representatives, with a fair process requiring at least an opportunity to present objections to the proposed action being contemplated.
2. Due process, including review by a Human Rights Committee, is implemented when it is proposed that a individual's rights be restricted for any reason.
3. A Human Rights Committee (HRC) reviews any restriction of an individual's rights including an assessment indicating the need for the restriction periodically, but at least annually, during the period in which the restriction is imposed, and documents such.
4. All restrictions are included in the individual's person-centered plan. When any restrictions are being proposed for an individual, the individual is supported to attend and provide input at the HRC meeting in which the proposed restriction is being reviewed.
5. Individuals are provided adequate training in due process procedures including:
   a. Any procedures for placing a limitation or restriction on an individual's rights'
   b. Training that supports the removal of a rights restriction.
6. The continued need for the restriction is reviewed at least quarterly by the QDDP or more often at the request of the individual. All restrictions are included in the person-centered plan.

G. The Organization Has Access to A Working and Effective Human Rights Committee.

1. The organization utilizes a working and effective HRC that complies with the provisions of 580-3-26.
2. The HRC reviews policies, procedures and practices that have the potential for rights restrictions without individualized assessment.
3. The HRC reviews the frequencies and reasons surrounding the use of restraint for medical and/or behavior purposes.
4. The HRC meets at least quarterly.
5. The HRC is composed of a majority of individuals that are not employed by the program, and consisting of representatives from each of the following groups:
   a. Current and/or former service users,

b. Family members of service users,
c. Representatives of community support and advocacy organizations,
d. Local official,
e. Citizens at large,
f. Performance Improvement/Quality Enhancement staff (ex-officio)

6. The HRC does the following;
   a. Makes recommendations to promote individuals' rights,
   b. Proactively promotes and protects individuals' rights,
   c. Reviews reports of substantiated allegations of abuse, neglect, mistreatment and exploitation,
   d. Reviews other data that reveals practices with respect to human, civil and legal rights,
   e. Reviews research projects involving human participation to ensure the protection of the individuals who are involved,
   f. Assists on the review of rights related policies and procedures,
   g. Promotes rights related education and training programs,
   h. Reviews rights restrictions,
   i. Assists in monitoring activities; advise the program administrator on consumer rights-related grievances, Reviews rights related issues in behavioral plans.

H. Services Are Provided in A Safe and Humane Environment.

1. Adequate furniture, supplies and equipment are available as needed to support needs and outcomes of individuals served.
2. Furniture, supplies and equipment are in good repair and operating effectively.
3. Supplies, equipment or devices (such as adaptive, therapeutic, corrective, prosthetic, orthotic and mobility devices) that are for individual use are in good repair for the person who requires their use.
4. Food is available that is nutritious and is available in quantity and variety to meet individual's dietary needs and preferences and will be available at any time without restriction. Any restrictions to access to food must be based on individualized assessed need that is documented in the person-centered plan along with what efforts will be taken to try to reduce or remove the restricted access as soon as may be feasible. This rule applies to Home and Community-Based Services (HCBS) and settings.
5. The organization maintains current certification and licenses for operations and complies with all posting and notification requirements of the local, state and federal offices.

6.3.c. Dignity and Respect

Responsible Office: Quality Management
Reference: Administrative Code 580-5-30
Effective: October 1, 2020

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of dignity and respect.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD Waiver HCBS Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions:
Procedures:

A. Individuals Are Treated as Individuals First

1. The organization's policies and procedures reflect and reinforce;
    a. Courteous practices towards individuals,
    b. The avoidance of labels to describe individuals based on physical characteristics or disabilities,
    c. The practice of addressing individuals by their preferred names,
    d. Privacy in an individual's bedroom with furnishings selected and arranged by the individual, and
    e. Ensuring the setting is physically accessible to the individual.
2. The organization provides training to staff and volunteers on policies regarding dignity and respect
3. The organization's identifying information (name, letterhead, etc.) promotes a positive image of individuals, services, and supports.

B. The Organization Respects Individuals' Concerns and Responds Accordingly

1. The organization provides individuals supported and their legally authorized representatives with the information regarding filing complaints and grievances.
2. The complaint/grievance procedures include the name and telephone numbers of the local contact.
3. The designated local contact has the knowledge to inform individuals, families, and legally authorized representatives of the means of filing complaints and grievances and of accessing advocates, ombudsmen or rights protection within or outside the organization.
4. The grievance procedure information is available in frequently used areas, particularly where individuals receive services.
5. Notices include the toll-free numbers for the DMH Advocacy Office, the Alabama Disabilities Advocacy Program (ADAP), a federal protection and advocacy system, and the local Department of Human Resources office.
6. The organization provides access to individuals and advocates, including a DMH internal advocate and the grievance process, without reprisal.
7. Responses to grievances and complaints are provided in a timely manner per the agency's procedures.
8. Responses are made in a manner and format that is relevant and understandable.
9. The organization implements a system to periodically, but at least annually, review all grievances and complaints.

C. Individuals Have Privacy

1. The organization provides space for individuals to:

a. speak or interact with others in private
b. to open and read mail or other materials

2. The organization affords every individual the right to privacy.
3. Support staff demonstrate respect for individuals' privacy when:
   a. providing supports for bathing, dressing and personal hygiene in a private manner, and
   b. when entering personal spaces.

D. Supports and Services Enhance Dignity and Respect.

1. Practices enhance dignity and respect while recognizing individual choices and preferences.
2. Individuals receive needed supports to:
   a. ensure healthy hygiene and personal cleanliness
   b. choose clothing that is clean, fashionable, and fits
   c. decorate their personal spaces based on choice while maintaining environments that are safe and sanitary.
3. Transportation and other supports are provided so individuals can access community services in a manner similar to others.
4. The organization has policies related to privacy that address consent and the use of video surveillance and other electronic recording devices such as cell phones, cameras, video recorders, etc.

E. Individuals Have Meaningful Work and Activity Choices.

1. Personal assessments:

a. identify preferred work and activities,

b. identify practices to help individuals to make choices based on preferences and assist individuals to achieve goals.

2. Choices of activities and work encourage and promote age-appropriateness and a positive self-image. Options consider the individual's cultural background and preferences.
3. The organization provides individual assessments that identify preferred work activities, including assessing interest in competitive integrated employment, identifying practices to help individuals make choices based on preferences, and assisting individuals to achieve goals.
4. There are options for individuals that are age and culturally appropriate, normative, and promote a positive self-image and are identified preferences documented in the Person-Centered Plan (PCP) with appropriate goals and objectives.
5. The organization facilitates opportunities for competitive integrated employment and supports when employment is the choice of the individual and prescribed in the individual's PCP.

6.3.d. Natural Support Networks

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30
Effective: October 1, 2020

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of natural support networks.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD Waiver HCBS Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions: Natural Supports- Family, friends, and or community resources such as local organizations, clubs, places of worship, schools or other places where new and existing relationships can be built and facilitated outside of the organization that is important to the individual.
Procedures:

A. Policies and Procedures Facilitate Continuity of Natural Support Systems

1. The organization will have policies and procedures that define natural supports and acknowledge the importance of natural supports in promoting identity, personal security, and continuity for individuals served by the organization.
2. Natural Supports will be defined as family, friends, and community resources such as local organizations, clubs, places of worship, schools or other places where new and existing relationships can be built and facilitated outside of the organization.
3. Organizational policies and practices will reflect how to facilitate continuity in existing relationships and supports and or building new relationships using community resources.
4. Organizational policies and practices will reflect how organization will assist individuals in making and maintaining their natural supports.
5. Organizational policies and practices will reflect how organizations will assist individuals to contact their natural supports.
6. Organization's facilitation of natural supports will include promoting visits to the homes of families and friends to individual's setting. (NA for Day and Non-Congregate Services)
7. Organization's facilitation of natural supports will include promoting visits of families and friends to individual's setting. (NA for Day and Non- Congregate Services)
8. Organization's staff will consider individual's health, safety, and well-being while planning visits with family and friends. (NA for Day and Non-Congregate Services)
9. Training will be provided to staff and volunteers to develop and/or improve skills to support the individual's communication and contact with natural supports, especially families and friends.

B. The Organization Recognizes Emerging Support Networks

1. The organization will have a mechanism to identify and support existing and potential or emerging natural supports for each individual.
2. The organization will address ways to connect individuals to natural supports including addressing and overcoming barriers.
3. The organization will have strategies to build the capacity for natural supports based on individual's choices and preferences.
4. The organization will pursue the use of family members or close personal friends to assist individuals with decision-making.

C. Communication Occurs Among Individuals, Their Support Staff and Their Families

1. The organization will have internal communication systems for individuals, their support staff and families that:

a. provides choices about extent and frequency of contact with their natural support networks.

b. ensures inquiries from those in individuals' natural support systems are responded to in a natural and timely manner.

c. has a mechanism for legally authorized representatives, and others identified by individuals to receive information and be notified promptly and compassionately of incidents involving the individual.

2. The organization will maintain written contact information including records of names, addresses, and phone numbers of family and friends who are important to individuals.

3. The organization will include a variety of methods for helping individuals stay connected to natural supports.

D. The Organization Facilitates Each Individual's Desire for Natural Supports

1. The organization will document individuals' satisfaction with the amount of contact with their natural support system.

2. The organization will document individuals' involvement with their natural support systems.

3. The organization will clearly identify expectations related to visits or other interactions with natural supports based on the desires of the individual being supported.

4. The organization will provide private space for visits and interactions with members of the individual's natural support network.

6.3.e. Protection from Abuse, Neglect, Mistreatment, and Exploitation

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30, Community Incident Prevention and Management System (IPMS)
Effective: October 1, 2020

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of protection from abuse, neglect, mistreatment, and exploitation.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD Waiver HCBS Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions:
Procedures:

A. The Organization Implements Policies and Procedures That Define, Prohibit, and Prevent Abuse, Neglect, Mistreatment, and Exploitation.

1. The organization will implement a Community Incident Prevention and Management System (IPMS) as required by the Department of Mental Health (DMH), Division of Developmental Disabilities (DDD) to protect individuals served from harm and improve the organization's responsiveness to incidents for purposes of prevention of harm and risk management.
2. The organization will notify the DDD of all reportable incidents and take action in accordance with the Community IPMS.
3. The organization will develop policies and procedures that are consistent and comply with requirements of the Community IPMS. The policies and procedures will identify, define, prohibit, and prevent abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation.
4. Definitions of abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation will be comprehensive, specific, and consistent with Community IPMS definitions.

B. The Organization Promotes Freedom from Abuse, Neglect, Mistreatment, and Exploitation.

1. The organization will provide individuals with understandable information about their right to be free from abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation.
2. The organization will have a complaint process that is understandable and easy to use.
3. Individuals will be supported to report allegations of abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation.
4. Allegations reported by employees or others, including individuals supported by the organization, are managed consistently and in the same manner.
5. The organization will ensure individuals who cause injury or harm to themselves or others receive supports to replace those behaviors consistent with the Alabama Department of Mental Health, Division of Developmental Disabilities Behavioral Services Procedural Guidelines (DDD-PBS-01-05).
6. When there are allegations of abuse, neglect, mistreatment, including the unauthorized use of restraints, and exploitation or other reportable incidents, the organization will take immediate action and ensure individuals are protected.
7. The organization will assist individuals who have been subjected to abuse, neglect, mistreatment, including the unauthorized use of restraints, or exploitation to access supports to address the effects of the abuse even if:
    a. The abuse occurred before they entered into the organization's system of services or
    b. The perpetrator is another individual who receives supports.

8. Incidents resulting in injury where both the perpetrator and the victim receive services will be investigated or clinically reviewed to determine:

    a. if the occurrence of such an incident may have been the result of neglect and/or

    b. if additional supports are needed for the individuals involved.

C. The Organization Follows Reporting Requirements for Allegations or Suspected Incidents of Physical, Verbal, Sexual or Psychological Abuse, Mistreatment, Neglect, or Exploitation Regardless of Age.

1. The organization will follow minimum protocols as specified in DMH/DD Community IPMS guidelines for reporting, investigation, and follow-up processes.
2. The organization will have procedures for reporting incidents and injuries in accordance with all applicable laws and DMH/DD requirements, including the Community IPMS.
3. The organization will notify an individual's responsible relative/guardian immediately in the event of a medical emergency or death.

D. The Organization Ensures Objective, Prompt and Thorough Investigations of Each Allegation of Abuse, Neglect, Mistreatment, and Exploitation, and of Each Injury, Particularly Injuries of Unknown Origin.

1. The organization will provide documentation that it conducts investigations in accordance with timelines established by the Community IPMS guidelines.
2. The organization will follow the recommendations for incident and investigation reports in the Community IPMS.

E. The Organization Ensures Thorough, Appropriate and Prompt Responses to Substantiated Cases of Abuse, Neglect, Mistreatment, and exploitation and Associated Issues Identified in the Investigation.

1. The organization will document the internal investigation/review and follow up action of all allegations of abuse, neglect, mistreatment, including the unauthorized use of restraints, or exploitation.
2. The organization will ensure investigation outcomes and recommended actions are implemented in accordance with the Community IPMS Guidelines.
3. The organization will ensure an initial and comprehensive mortality review is completed and available.

F. Support Staff Knows How to Prevent, Detect, and Report Allegations of Abuse, Neglect, Mistreatment, and Exploitation.

1. The organization will ensure all staff receive orientation on what constitutes abuse, neglect, mistreatment, and exploitation. This includes prevention, detection and reporting requirements as specified in internal agency procedures, Community IPMS Guidelines, and any other applicable federal or state requirements.
2. The organization will ensure staff with specific responsibilities related to reporting, investigating, or documenting requirements contained in the Community IPMS receive appropriate training in their areas of responsibility and in specific procedures as well.
3. The organization's policy and practice will demonstrate continuous efforts to ensure freedom from abuse, exploitation, neglect or mistreatment are demonstrated. Efforts will include ongoing training in prevention, detection, and reporting and occur frequently enough, but at least annually, to support both individual and organizational outcomes.
4. The organization will provide training on specific supports, services, policies and procedures, or other corrective action deemed appropriate, immediately when support staff competency is identified as a (potential) causal factor for substantiated incidents of abuse, exploitation, neglect or mistreatment, including the unauthorized use of restraints, and exploitation.
5. The organization will evaluate potential underreporting and screening of allegations of abuse, neglect,

mistreatment, including the unauthorized use of restraints, and exploitation and provides additional training as needed.

6. The organization will develop and implement policies and procedures consistent with Section VIII of the Community IPMS and their internal quality improvement system process that reports incident data and identifies trends, patterns or isolated incidents that may be indicative of abuse, neglect, mistreatment or exploitation

6.3.f. Best Possible Health

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30, Alabama Board of Nursing Administrative Code 610-X-7, MAS Nurse Manual
Effective: October 1, 2020

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of Best Possible Health.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD Waiver HCBS Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions:
Procedures:

A. Individuals Have Supports to Manage Their Own Healthcare

The organization's policies and procedures must ensure:

1. Individuals are given the opportunity to choose health care providers as desired.
2. Individuals are supported to make their own health care appointments and choices regarding their medical care as needed.
3. Individuals are provided understandable information about their current and past health conditions, their medications and their treatments, including the purpose, intended outcomes, side effects or other risks and alternatives.
4. Individuals have access to all their health care records.
5. An Individual's preferences and ability to self-administer medications and treatments are assessed at least annually in compliance with the Nurse Delegation Program.
6. Supports are available to assist individuals with medications and treatments if necessary.
7. Individuals are supported to become knowledgeable about how to access emergency medical care and to access it as needed.

B. Individuals Access Quality Healthcare

1. Within three hundred sixty-five (365) days prior to initial admission to a community-based program or service, each individual has a physical examination conducted by a licensed physician or certified nurse practitioner.
2. Individual's medical status and needs are reviewed annually within ninety (90) days prior to or at the same time as the annual Person-Centered Plan meeting. This is evidenced by a report from a physical examination by a licensed physician or certified registered nurse practitioner conducted within the last year.
3. Individuals are assisted in obtaining preventive and routine health services including physical examinations, immunizations, and screenings consistent with their age and risk factors as recommended by their personal physician. Preventive health care strategies/interventions contained in the Person-Centered Plan, based on the individual's current health status and age, are implemented and will be carried out according to the Centers for Disease Control recommendations regarding preventive/screening practices. Emphasis will be placed on age-specific screening tests.
4. Each individual newly admitted to a program has a TB skin test with documented results, unless there is written evidence that such testing was previously done or there is a medical contraindication for the procedure. An annual TB skin test is conducted as medically indicated. If the skin test yields a questionable result, the organization follows up with a physician for necessary screenings and/or treatments.
5. Individuals who require supports for mobility are provided with assistance and supports to prevent skin

breakdown. Individuals have therapeutic and adaptive equipment that fits them and is in good repair.

C. Health Needs Are Addressed in A Timely Manner

1. An individual who develops a medical problem, either an emergency or acute health care change, is assessed in a timely manner. Treatment/care and monitoring of the individual's condition is provided in accordance with good standards of nursing or medical care to resolve the problem effectively.
2. The organization has systems in place that ensure ongoing communication between individual's health care support staff and outside health care staff promotes continuity of care.
3. Each individual's Person-Centered Plan indicates his/her health needs and outlines specific actions and time frames to address these needs. Actions taken are documented. Health needs include, but are not limited to, physical, neurological, dental, nutrition, vision, hearing, speech/language, PT/OT,0 and psychiatric services.
4. When available, individual's records document hospital summaries that include the discharge diagnosis, current health status, necessary follow-up instructions and any restrictions or limitations of recent hospitalizations. Organizations shall document efforts to obtain hospital summaries.
5. Individual's records document acute health changes to provide a clear picture of the course of the illness or injury, the treatment provided, and the individual's current status from the time of identification through resolution.
6. As part of the Person-Centered Plan, health care plans and supports are modified in a timely manner based upon acute health care changes.

D. Staff Immediately Recognize and Respond to Medical Emergencies

1. Direct support staff (non-licensed medical personnel) receives training to recognize and respond to individuals experiencing medical emergencies.
2. Provide medical equipment ordered by a physician to respond in a potential emergency for pre-existing (known) conditions, ensuring it is well maintained, clean and functional.
3. Provide medication ordered by a physician to respond in a potential emergency in the appropriate dose, quantity, and form.
4. Ensure first aid kits are available and appropriately stocked for the provision of initial care for an illness or injury.

E. People Receive Medications and Treatments Safely and Effectively

1. Organizations implement policies and procedures approved by their Boards of Directors requiring full compliance with the Alabama Board of Nursing's Regulation 610-X-7-.06, Alabama Department of Mental Health Residential Community Programs.
2. The unit dose or individual prescription system is used for all prescription drugs.
3. All medications are labeled and stored in accordance with criteria herein.
    (a) Medications are stored under lock and key.
    (b) All narcotic medications, Schedule 2, 3, 4, and 5 are stored under double lock and key.
    (c) Medications are stored separately from non-medical items.
    (d) Medications are stored under proper conditions of temperature, light, humidity, sanitation, and ventilation.
    (e) Internal and external medications are clearly labeled as such and stored separately from each other.
    (f) The organization is able to document ongoing accountability for all prescription medication through an inventory process.
4. Medications, both prescription and non-prescription, are administered and recorded according to valid orders

and in compliance with the Alabama Board of Nursing's Regulation 610-X-7-.06, Alabama Department of Mental Health Residential Community Programs, and the Nurse Delegation Program.

5. Prescription medications are used only by the individual for whom they are prescribed. Over the counter (OTC) medications are issued to or retrieved by an individual from his/her own supply in accordance with the Nurse Delegation Program.
6. Each prescription medication which is identifiable up to the point of administration. Identifiable means that it is clearly labeled with the name of the individual, name of the medication, and the specific dosage. Prescription medication labels state the expiration date. Names of medications on labels match the Medication Administration Record.
7. All medication errors and reactions to medications are recorded and reported in accordance with written policy, the Community Incident Prevention and Management System (IPMS) Guidelines, and the Nurse Delegation Program.
8. Documentation of corrective action taken regarding medication errors, is maintained by the agency for five years.
9. Discontinued and outdated medications are promptly disposed of in a safe manner. Disposal can be implemented only by a nurse, pharmacist, or physician and must be witnessed and documented in accordance with policy.
10. Each individual who receives medication receives medical supervision by the prescribing physician, to include regular evaluation of the individual's response to the medication.
11. Individuals receiving psychotropic medication are seen and evaluated by a licensed physician, preferably a psychiatrist, at intervals not to exceed a six (6) month period. Reviews of the use of psychotropic medications for each individual are conducted by a licensed physician to ensure the drug is effective, is being given at the lowest possible dosage and is consistent with appropriate standards of care.
    (a) Factors/criteria to be taken into account for consideration of psychotropic medication reduction(s), are identified, assessed, and documented. Potential reduction of the psychotropic medication is discussed with the physician and documented and may only be ordered by a physician.
    (b) Blood level examinations for individuals receiving anti-convulsant and psychotropic drugs are repeated as often as clinically indicated for potential toxic side effects and to ensure levels are within therapeutic range. Results of most recent blood level examinations are maintained in any organization in which medications are administered. In the event a copy of blood work cannot be obtained, a letter from the physician stating the individual is in his usual state of health is adequate.
12. Individuals may administer their own medication when all the following have been established and documented in accordance with regulations of the Nurse Delegation Program:
    (a) The individual has been provided with information regarding the purpose, dosage, time, and possible side effects of the medication and has verbalized/effectively communicated understanding.
    (b) The individual has been instructed regarding what to do and who to call if a dose is missed, if extra medication is taken, or if adverse reaction is experienced and has verbalized/effectively communicated this understanding.
    (c) The individual has been educated in the maintenance of his/her own medication history and in the recording of information needed by the physician to determine medication and dosage effectiveness. The individual has verbalized/effectively communicated understanding and can perform a competent return demonstration of self-administration of medication.
13. Medication utilized by an individual for self-administration is not locked away from him/her. However, it is secured out of reach of other individuals who have not been determined to be capable of self-administering his/her own medication.

14. Self-medication desire and safety is discussed during the individual's annual Person-Centered Plan meeting and any concerns noted in this area are addressed and documented.
15. The organization supports self-administration of medication through periodic monitoring of administration and documentation of continued proficiency by the individual.
16. For residential and day services, there is a Medication Assistance Supervising (MAS) trained registered nurse or licensed practical nurse as a full-time or part-time employee or consultant to the provider responsible for supervision of delegation of medication assistance to the unlicensed personnel.
17. In residential services, access to an on-call MAS nurse must be available twenty-four (24) hours a day, seven (7) days a week.

6.3.g. Safe Environments

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30, Administrative Code 580-3-22
Effective: October 1, 2020

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of safe environments.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD Waiver HCBS Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions:
Procedures:

All environments must be designed and maintained to be accessible, safe, and sanitary for individuals.

A. The Organization Provides Individualized Safety Supports.

1. Safety supports within an environment are available to the extent they are needed, based on a required functional assessment.
2. Assessment includes, but is not limited to, safety in the kitchen, ability to adjust hot water, ability to evacuate in the event of fire or severe weather, call for help, use cleaning supplies, and other safety concerns specific to the individual or the particular living environment.
3. Assessment results are documented.

B. The Physical Environment Promotes Individual's Health, Safety, and Independence.

1. Kitchen areas, electrical appliances, and outlets are free of any unnecessary hazards.
2. The organization assures the building temperature is comfortable for individuals served, according to weather conditions (a normal comfort range in most instances is defined as not going below a temperature of 70-F or exceeding a temperature of 80-F).
3. Environments are clean, pest free, and adequately maintained to ensure basic safety.

C. The Organization Has Individualized Emergency Plans.

1. Organizations have emergency plans to deal with a variety of situations and accommodate the specific needs of each individual.
2. Appropriate visual signs and alarms are in place for individuals who need them.
3. Quarterly severe weather drills and monthly fire drills are conducted, documented, and available.
4. Emergency contact numbers are readily available and accessible to staff and individuals receiving supports.

D. Routine Inspections Ensure Environments are Sanitary and Hazard Free.

1. The organization monitors housekeeping, conducts regular safety inspections, and completes routine maintenance and repairs to ensure safe conditions throughout any physical structures. A system is in place to immediately report and correct environmental or safety hazards.
2. The organization maintains records of repairs and maintenance work and of internal inspections to ensure safety and sanitation. Indoor air pollution, inadequate heating and sanitation, structural problems, electrical and fire hazards and older homes with lead-based paint hazards must be addressed in the agency's monthly environmental rounds safety program.
3. Each organization adheres to the applicable certification and licensure standards, statutes, and regulations regarding the physical environment as required by the Alabama DMH Administrative Code Chapter 580-3-22 Minimum Standards for Physical Facilities.
4. The organization maintains the appearance of the setting, inside and out, consistent with that of other settings

in the neighborhood. This rule applies to Home and Community Based Services (HCBS) and settings.

6.3.h. Staff Resources and Supports

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30
Effective: October 1, 2020

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of staff resources and supports.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD Waiver HCBS Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions:
Procedures:

A. The Organization Implements a System for Staff Recruitment and Retention.

1. The organization will recruit and hire staff in accordance with all applicable laws and organizational requirements.
2. All employees/agents will have references and background checks prior to employment. A national background check is required. Volunteers who work **unsupervised** with individuals receiving supports will be subject to the aforementioned background check.
3. Background checks must consist of the following personal identifiers; name, social security number, date of birth, and driver's license or state issued non-driver's identification. The following criminal activities will permanently disqualify a potential employee from employment;
    a. Convictions for any crime of violence
    b. Convictions for any felony
    c. The following criminal convictions will prevent a potential employee from employment for the time specified;
        - Reckless endangerment in the past five (5) years
        - Stalking in the second degree in the past five (5) years
        - Criminal trespassing in the first degree in the past five (5) years
        - Violating a protective order in the past three (3) years
        - Unlawful contact in the first degree in the past (3) years
        - Unlawful contact in the second degree in the past year
        - Criminal mischief in the first degree in the past seven (7) years
4. The organization will complete pre-employment drug screening for each employee whose job duties involve the care, safety, and well-being of individuals, and on reasonable suspicion, for cause, of any employee of the organization.
5. The organization will require all new staff that have direct contact with individuals supported to have a TB skin test with documented results, unless there is written evidence that such testing has been done within the last year unless there is a medical contraindication. The TB testing must be administered, read and documented by healthcare professionals who are not employees of the Direct Service Provider.
6. Annual TB testing of employees is not a requirement; however, the organization will annually provide documented ADMH approved TB education training for each employee who has direct contact with the individuals served. This annual education can be completed by healthcare professionals who are employees of

the Direct Service Provider.

7. The organization will assess, at least annually, and adjust hiring practices based on analysis of position turnover, availability of qualified candidates, vacancy rates, staffing ratios, availability of financial resources, supports needed by individuals and other relevant data.
8. The organization will work with state and local resources such as schools and job placement services to ensure an adequate supply of qualified candidates.
9. The organization will conduct employee satisfaction surveys, including exit surveys when employees leave.
10. Satisfaction surveys will be reviewed for suggestions to improve recruitment and retention.

B. The Organization Implements Policies and Procedures That Promote Continuity and Consistency of Staff.

1. The organization will have an adequate number of personnel and staff to carry out the stated purpose/mission
2. Individuals supported will have adequate staff to provide needed services and supports so expectations, needs, and desired outcomes can be achieved.
3. The organization will maintain records demonstrating staff accountability.
4. The organization will maintain records demonstrating staff assignments and/or staff schedules.
5. The organization's hiring practices, and staffing plan will be shaped by supports needed by, and individualized for, those receiving services.

C. Staff are Qualified for Their Roles.

1. Employees who directly provide supports to individuals will be at least 18 years of age and have the educational background and licensing credentials as required by the funding source, state law, and federal law.

    a. Residential care direct support employees will have a minimum of a high school diploma or GED/High School Equivalency Certificate.
    b. Personal care direct support employees must be able to read and write and follow instructions.
    c. Respite care direct support employees must have at least completed tenth grade and must be able to read and write and follow instructions.
    d. Day habilitation direct support employees must be able to read and write and follow instructions
    e. Adult companion services direct support employees must have the ability to read and write and follow instructions.

2. Executive Directors/Owners/Operators will possess a bachelor's degree from an accredited institution in Public Health, Special Education, Social Work, Business Administration, Public Administration, Psychology, or other Human Services field working with individuals with various disabilities or have a current Registered Nurse's license. The executive director will have considerable experience (5 or more years) working with individuals with intellectual and/or developmental disabilities in community settings. The director must possess, or be eligible for, license or certification in their particular field if applicable.

3. Support Coordinators at minimum, have a Bachelor of Arts or a Bachelor of Science degree, preferably in a human services related field or social work program with specialized training and a four year college degree and will complete a Support Coordinator training program approved by the ADMH/DDD and the Alabama Medicaid Agency.

4. All Qualified Developmental Disabilities Professionals (QDDP) will have the minimum educational background required, Doctor of Medicine or osteopathy, registered nurse, or a bachelor's degree, in a human service field or a bachelor's degree with 12 hours course credit in a human services field.

5. All QDDPs will have at least one year of experience working directly with individuals with intellectual or other developmental disabilities and will complete QDDP training offered by the state.

6. Students completing a degree in psychology, counseling, social work or psychiatric nursing, will provide direct services only under the following conditions: the student is in a clinical practicum that is part of an officially sanctioned academic curriculum; receives a minimum of one hour/week direct clinical supervision from a licensed/certified mental health professional with at least 2 years post master's experience in a direct service functional area; and the student's clinical notes are co-signed by the supervisor.

The organization will ensure employees maintain current certifications and licenses as required.

D. The Organization Implements an Ongoing Staff Development Program.

1. The organization will assure orientation/training for each employee.
2. The organization will maintain records documenting all employees training on site.
3. Prior to assuming their assigned positions, all employees will complete training in each of the following areas:
    - Rights of individuals served
    - Complaint/grievance procedure
    - Policies and procedures regarding abuse, neglect, mistreatment and exploitation
    - Overview of intellectual/developmental disabilities
    - Infection control/universal precautions
    - Severe weather preparedness
    - Fire Safety
4. Prior to working alone, and within at least 90 days of employment, all employees who provide direct supports to individuals will receive training in:
    - CPR (must receive certification)
    - First aid (must receive certification)
    - Medical emergencies
    - Management of aggressive behavior
    - Medication training including medication side effects
    - Signs and symptoms of illness
    - Incident identification/reporting in accordance with the IPMS
5. Prior to working alone, and within 90 days of employment, all staff who provide direct supports will receive training needed to implement individuals' plans.
6. Within 90 days of employment, all staff who provide direct supports to individuals will receive training in each of the following:
    - Agency policy and procedures
    - Philosophy of self-determination
    - Person-centered supports
    - General behavioral principles with emphasis on skill acquisition and behavior reduction techniques
7. The organization will annually provide refresher training for all employees in each of the following areas:

- Rights of individuals served
- Complaint/grievance procedure
- Policy and procedures on abuse, neglect, mistreatment and exploitation
- Infection control/universal precautions

8. All direct support staff will be provided annual training in management of aggressive behavior.
9. Medication Assistant Certified (MAC) trained employees will be evaluated in compliance with the Nurse Delegation Program.
10. The staff training program will be developed based on input from individuals supported and their families/legally authorized representatives
11. Staff training will reflect current best practices
12. Training for staff will include one or more of the following:
    - Mentoring
    - On the job support
    - Personal growth and development planning or
    - Competency based measurement
13. All employees who provide direct supports will maintain current certifications in CPR and First Aid

6.3.i. Positive Services and Supports

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30
Effective: October 1, 2020

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of positive services and supports.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD Waiver HCBS Providers; Support Coordinator Services
Definitions: Behavioral Services Procedural Guidelines (BSPG)- Provides information and guidance for developing and implementing behavioral services for individuals.
Psychological and Behavioral Services (PBS) Describes several behavior support procedures and ranks them in terms of their restrictiveness. The PBS is found within the BSPG. Both are referenced in this Operational Guideline.
Procedures:

A. Individuals Are Informed About the Services and Supports the Agency Provides.

1. The agency will discuss with the individual receiving supports and the legally authorized representative the organization's services and any related charges, including any limitations placed on the duration or services.
2. The agency will provide a written statement of services and related charges to every individual receiving supports and the legally authorized representative.
3. Individuals responsible for payment of charges for services must be informed of any changes in services or limitations placed on duration of services prior to their occurrence during the service relationship.
4. The information must be provided to the individual in language and terms appropriate to the individual ability to understand.

B. Individuals Are Provided Assistance in Making Choices and Planning for Services and Supports.

1. Each individual will have a support team that includes:
    a. a Qualified Developmental Disabilities Professional (QDDP)
    b. the legally authorized representative or advocate as needed,
    c. family members (as desired by the individual and/or legally authorized representative),
    d. representatives of all service providers (particularly staff responsible for program implementation),
    e. Support Coordinator, and
    f. others as indicated by the individual's life situation, needs, desires, and age (in the case of children), or as requested by the Individual or determined to be of important support.
2. When individuals enter the program, the QDDP will share pertinent information regarding the individual's support needs, including medical care, safety concerns, etc. with Support Team members within 24 hours.
3. There must be documentation included in the individual's record of information shared and those attending the initial support team meeting.
4. Within 30 days of entry into the program, the team will meet to develop a Person-Centered Plan.

5. The team will meet at least annually, every 365 days, to review and update the individual's plan.
6. The team will meet at the convenience of the individual and other members of the team to develop the Person-Centered Plan.
7. Each individual and his/her family members, or others with permission of the individual, must be invited to actively participate in Person Centered Plan meetings, including transition or discharge planning.
8. The individual and/or legally authorized representative must be prepared for the Person-Centered Plan meeting by sharing information to be discussed prior to the scheduled meeting, except in the event an emergency meeting is necessary. Information must be presented to the individual in a method, language, and/or terms appropriate for them to understand.

C. The Organization Assesses the Individual's Personal Goals and Priority Services and Supports.

1. Each individual will have a current functional assessment. If the individual is new to the organization's services, the assessment must be completed no later than 30 days after entry into services.
2. The functional assessment must be updated annually in conjunction with the Person-Centered Plan.
3. The assessment will address all the following areas at a minimum:
    a. individual's preferences,
    b. family/home situation,
    c. health needs,
    d. activities of daily living,
    e. vocational needs,
    f. communication skills,
    g. leisure activities,
    h. physical supports, i.e. adaptive equipment, and
    i. social supports

D. Individuals' Plans Lead to Person-Centered and Person--Directed Services and Supports.

1. Individuals will have Person Centered Plans based on their strengths, interests, and needs.
2. Person Centered Plans will focus not only on skills and supports available to the individual but on those are preferred by the Individual or needed to realize Individual goals as documented in the functional assessment.
3. Person Centered Plans will include learning, participation and support opportunities that are meaningful, functional, and enhance the Individual's dignity.
4. Information for Person Centered Plans must be obtained directly from the individual to the greatest extent possible or from others who know the Individual best.
5. Information for Person Centered Plans will include observations of the Individual.
6. Person Centered Plans will incorporate information from team members who know the individual well.
7. Person Centered Plans must be modified by individuals with their support teams as needed, as soon as possible when there are significant changes in the Individual's physical or mental condition, and/or when a major life change is being contemplated by the individual or for the individual.
8. The organization will have a clearly defined process for convening special Individual -centered planning meetings. Meetings must be called at any time mutually agreed upon by the Individual and/or advocate or legally authorized representative and his/her team.

9. Person Centered Plans will include prioritized goals designed to achieve desired individualized outcomes. Desired individual outcomes must be defined in such a way that they address the Individual's preferences, are attainable within a specific timeframe and enhance the Individual's life.
10. Goals will include participating in community life, gaining and maintaining satisfying relationships, having opportunities to fulfill respected social roles, expressing preferences and making choices, and continuing the development of Individual competencies.

E. The Organization Provides Continuous and Consistent Services and Supports for Each Individual.

1. All identified formal supports will include implementation strategies defining who is responsible, when, where and how the opportunity is carried out, including the frequency, and methods of data collection to assess achievement.
2. Staff will possess the knowledge, skills and abilities to implement Individuals' Person-Centered Plans as written.
3. Staff will receive training in how to provide or access the supports needed to implement goals in each individual's plan.
4. The organization will provide documented evidence that individuals are offered at least one community integration activity per week.
5. The organization will have a system for ensuring that changes are effectively communicated to everyone within the organization who is important to the Individual or who provides supports to the Individual and ensures appropriate training if any special skills are needed.

F. The Organization Monitors the Effectiveness of Each Individual's Person-Centered Plan.

1. The organization will have a system to monitor implementation of Person Centered Plans that include direct observation of services and supports as well as reliable recorded evidence or information that reflects progress toward objectives and achieving desired outcomes.
2. The implementation of Person Centered Plans must be reviewed and documented at least every 90 days for effectiveness.
3. The review will include progress/achievement for each learning, participation, or service opportunity.
4. Person Centered Plans must be modified by individuals with their support team if the individual is not benefiting from identified opportunities or as requested by the individual.

G. The Organization Provides Positive Behavioral Supports to Individuals.

1. Person Centered Plans will include objectives and strategies to address behaviors that interfere with the achievement of individual goals or exercise of individual rights.
2. Strategies to address behaviors will use the least intrusive interventions necessary and the most positively supporting interventions available.
3. When appropriate, individuals will have Behavior Support Plans that reduce, replace, or eliminate specific behaviors.
4. Behavioral Services Procedural Guidelines must be followed when implementing Behavior Support Plans.
5. Behavior supports must be developed by a qualified professional based on information gathered in a

functional assessment.

6. Functional assessments will identify physical and environmental issues that need to be addressed to reduce, replace, or eliminate behaviors.
7. Support plans will describe specific behavioral supports that may and may not be used.
8. Behavior Support Plans will include a plan to reach a functionally equivalent behavior that will take the place of a target/inappropriate behavior. BSPG-PBS-02
9. Direct support staff will receive training in behavioral techniques and plans prior to implementation of supports to individuals.
10. The organization will review data related to the effectiveness of behavior supports. The data is reviewed at least quarterly, or more often as required by individual needs.
11. Quarterly reports will summarize the behavioral/psychiatric symptom data. BSPG— PBS-04
12. Data will indicate whether the intervention(s) is effective. BSPG—PBS-04
13. Monitoring will include information explaining why behaviors/symptoms have worsened. BSPG—PBS-04
14. If no progress is made in three months, the Behavior Support Plan must be modified. BSPG—PBS-04
15. The report will include graph(s) of targeted reduction behaviors. BSPG-PBS-04

H. Individuals Are Free from Unnecessary, Intrusive Interventions.

1. Prior to imposing a rights restriction, an assessment must be completed indicating the need for the restriction. The Individual will meet with the support team to discuss the reason for the proposed restriction, except in extreme emergencies to prevent the individual from harming self or others.
2. Criteria for removing the restriction must be developed and shared with the individual, and legally authorized representative, prior to imposing the restriction.
3. The individual, or the legally authorized representative, will give informed consent for any Behavior Support Plan that includes Level 2 or greater procedures.
4. Behavior Support Plan that include Level 2 or 3 interventions must be reviewed and approved by the Behavior Program Review Committee, the Human Rights Committee, and the individual, or the individual's legally authorized representative.
5. All reviews and approvals must be updated annually. BSPG PBS-03
6. Emergency or unplanned behavior interventions that are highly intrusive, level 3, will not be used more than three times in a six-month period without a team meeting to determine needed changes in the individual's Behavior Support Plan.
7. If Individuals require behavioral or medical supports to prevent harm to themselves or others, supports must be provided in accordance with DDD-PBS 01-05.
8. Restraint devices and other restraint procedures will only be applied by staff with demonstrated competency for the device/ procedure.
9. The organization will ensure individuals are not subjected to highly intrusive behavior interventions or punishment for the convenience of staff, or in lieu of a Behavior Support Plan.
10. The organization will prohibit the use of corporal punishment, seclusion, noxious or aversive stimuli,

forced exercise, or denial of food or liquids that are part of an individual's nutritionally adequate diet.

11. Requests for the use of Level 4 intervention procedures, except for Emergency Mechanical Restraint, must be sent to the Director of Psychological and Behavioral Services for the Division of Developmental Disabilities after reviews have been completed by the Behavior Program Review Committee, Human Rights Committee, and the legally authorized representative. All restraints approved through the BSP process must be documented in the Person-Centered Plan. The QDDP will review at the frequency directed by the Director of Psychological and Behavioral Services.
12. The agency will document and comply with the limit for use of Emergency Mechanical Restraint as required by the IPMS.

I. The Organization Treats Individuals with Psychotropic Medications for Mental Health Needs Consistent with Standards of Care.

1. The use of psychotropic medications for behavior support and use of medication to reduce or change behaviors associated with psychiatric symptoms will comply with provisions of DDD PBS Level 3, including incorporation into a Behavior Support and/or Psychotropic Medication Plan.
2. PRN orders for psychotropic medications must be administered in accordance with Nurse Delegation Program and in compliance with emergency procedures and due process.
3. The individual's Support Team will meet to assess and address behavioral and psychiatric needs when PRN medications are used as an emergency procedure three times within a six-month period.
4. If an individual has a Psychotropic Medication Plan because they receive psychotropic medication(s) and have not exhibited a targeted behavior in six months, the Psychotropic Medication Plan must be reviewed and approved by the Behavior Program Review Committee at least annually. BSPG—PBS-03

6.3.j. Continuity and Personal Security

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30
Effective: October 1, 2020

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of continuity and personal security.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD Waiver HCBS Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions:
Procedures:

A. The Governing Body Provides Leadership.

1. Each organization will have a Governing Body which maintains and has the following documents/information available for review onsite:
    a. written board approved operational policies
    b. articles of incorporation (or a charter) with bylaws
    c. a current organizational chart that is updated regularly, but at least annually, and identifies the titles of employees
    d. a written mission statement approved by the Board of Directors
2. Responsibilities of the board must be defined in writing.
3. Records/minutes of Board meetings will be maintained and available for review.
4. The Executive Director will be responsible for the overall operation of the agency. This responsibility will be included in the job description for the Executive Director
5. The organization will have a written mission statement consistent with its legal constituting documents describing its purpose, services/supports it provides, who receives services, and how expectations of those who receive services and supports are met.
6. The mission and values statement will clearly reflect the organization's commitment to protect individuals' rights.
7. The mission and values statement will reflect the organization's provision and availability of services through positive approaches that are dignified, respectful, and demonstrate achievement of outcomes unique to each individual.
8. The board will review the mission and values statements on a regular basis, but at least annually.
9. A system will be in place for receiving input from current and prospective service users in development of the organization's mission statement, values, and its ongoing organization and operations, as well as the opportunity to provide feedback to participants for required or desired changes
10. The system for providing input or feedback will be developed and maintained in a form that is easily used and understood by individuals receiving services and supports.
11. The organization will conduct flexible operations that meet individual needs in terms of accessibility and availability for those receiving services and supports.
12. The organization will maintain current certifications and licenses for operations and comply with all posting and notification requirements of local, state, and federal offices.

B. The Organization Supports Individuals to Manage and Access Their Personal Money.

1. The organization will refrain from engaging in accounting/ fiscal practices that restrict individuals from having access to their personal money.
2. The organization will, when assisting individuals with money management, provide the individual,

   legally authorized representative, and others identified by the individual with documented financial statements of all expenditures and excess funds at least quarterly.

C. The Cumulative Record of Personal Information Promotes Continuity of Services.

1. The organization will maintain a cumulative record of information and documentation of services and supports needed by and provided to individuals.
2. The organization will have:
   a. a system for protecting the confidentiality of records, including financial and health information, in accordance with HIPAA regulations and other applicable state and federal laws.
   b. a system to ensure only those directly involved in an individual's care, or involved in authorized administrative review or service monitoring have access to records
   c. a system for ensuring records are safe from loss, destruction, or use by unauthorized persons.
3. The organization will ensure that birth certificates, Social Security cards, eligibility paperwork, and other legal documents are maintained permanently, and all other records are maintained for five years
4. The organization will ensure the individual's current record includes at least 12 consecutive months of information.
5. The organization will ensure personal information includes only information needed to provide services and supports to individuals.
6. The organization will ensure personal information contained in the record is accurate and legible.
7. The organization will ensure information is organized so it is accessible and able to be updated on a regular basis.
8. The organization will ensure individuals and their legally authorized representative have access to all

   individual information in their record and is able contribute to the information if they choose to do so.

6.3.k. Quality Improvement System

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30
Effective: October 1, 2020

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of a quality improvement system.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD Waiver HCBS Providers; Support Coordinator Services; ADMH-DDD Central Regional Offices
Definitions:
Procedures:

A. The Organization Monitors Quality Improvement.

1. The organization will have a written internal monitoring plan approved by their board of directors annually and will be available for review by designated DDD staff.
2. The internal monitoring system will measure the most important elements and key functions of the organization.
3. The organization will monitor, at a minimum, the following areas:

   (a) Promotion and protection of individual rights.

   (b) Dignity and respect practices.

   (c) Promotion of natural supports.

   (d) Protection from abuse, neglect, mistreatment, and exploitation, including implementation of an incident prevention and management system.

   (e) Best possible health, including implementation of the Nurse Delegation Program.

   (f) Safe environments.

   (g) Staff resources and supports.

   (h) Positive services and supports, including implementation of the Behavioral Services Procedural Guidelines.

   (i) Continuity and personal security.

B. A Comprehensive Plan Describes the Methods and Procedures for Monitoring Quality Improvement.

1. The organization will clearly identify data sources, methods for data collection and the type of data analysis to be performed for each function measured.
2. The organization will identify individuals responsible for collecting and analyzing data from the internal monitoring system.
3. The organization will identify responsibilities and roles of each individual involved on the internal monitoring team and include individuals supported.

C. Quality Improvement Monitoring Data is Used for Continuous Learning and Development.

1. The internal monitoring system will emphasize quality enhancement and continuous improvement.
2. Data collected, and information learned from the internal monitoring system will be used to inform and educate staff and individuals receiving services, improve systems, and ensure quality improvement is met.

6.3.l. Personal Care, Companion, Respite and Crisis Intervention Services, and Supported Employment at an Integrated Worksite

Responsible Office: Quality and Planning/Certification
Reference: Administrative Code 580-5-30
Effective: October 1, 2020
Revised: March 26, 2021

Statement: This process is to guide certification staff in assessing the community provider's compliance with providing quality supports in the area of personal care, companion, respite and crisis intervention services, and supported employment at an integrated worksite.
Purpose/Intent: To provide a process to ensure the provider practices sound management providing quality services to individuals.
Scope: DDD Waiver HCBS Providers; Support Coordinator Services; ADMH-DDD Central Regional Offices
Definitions:
Procedures:

A. Staff Providing Services Know How to Support the Individual.

1. In addition to administrative requirements in Chapter 580-5-30-.10, the organization will provide training to staff on the services to be provided and how the individual wants to be supported. This training will include:
    a. Review of the Person-Centered Plan.
    b. Information about specific conditions and required supports of the individual to be served, including his/her physical, psychological or behavioral challenges, his/her capabilities, and his/her support needs and preferences related to that support.
    c. Reporting and record keeping requirements.
2. The organization will provide procedures for arranging backup workers when needed.

B. The Organization Develops and Implements a Person-Centered Plan.

1. A Person-Centered Plan will be developed and approved for the individual receiving services, and there is documentation establishing that the plan is followed and is modified as needed.
2. The Person-Centered Plan will be adequately detailed so the worker can provide the services required by the individual.
3. The Person-Centered Plan will be approved by the Division of Developmental Disabilities, if services exceed eight (8) hours per day of services and documents the following:
4. If providing respite services, the organization will provide evidence that a temporary support plan was developed prior to the service and is documented and implemented for the individual while served by the organization.
5. The Person-Centered Plan will be developed with input from the individual, their legally authorized representative, family, and/or advocate.
6. If the individual's needs require more than eight (8) hours of personal care or companion service per day, the individual and his/her team will meet to discuss a viable alternative service which will meet his/her needs.
7. If the individual and his/her team decides personal care, companion, respite, and/or crisis intervention services are no longer adequate, a viable alternative service will be located prior to discharge.

C. Services Are Monitored

1. Documentation of the provision of identified services/supports will be available.

2. A QDDP will be assigned to supervise the provision of personal care, companion, respite and crisis intervention services to the individual, evaluate the continued appropriateness of such services, and makes changes when the individual's needs or desires are not being met.
3. The QDDP will conduct a site visit at least every ninety (90) days, and more often if needed. For Personal Care and Companion Care, QDDP on-site supervision must occur every 60 days, to include the required supervisory EVV log-in. **(Note: Failure to complete timely supervisory EVV log-in will result in denied claims).**
4. The QDDP will assess the effectiveness of the service, individual/family satisfaction with the service, and institutes any changes that are needed.
5. Documentation will be made establishing that the QDDP has taken corrective or improvement action in a timely manner, as need indicates.

7.1.a. Behavior Support Plan Writing and Content

Responsible Office: Psychological and Behavioral Services
Reference: ADMH Administrative Code 580-5-30; Behavioral Services Procedural Guidelines: DDD-PBS, HCBS Waiver Manual
Effective: April 1, 2021

Statement: An individual receiving HCBS waiver services from the Alabama Department of Mental Health, Developmental Disabilities Division, is required to be provided with a Person- Centered Plan of services, which could include a Behavior Support Plan where applicable.

Purpose/Intent: To provide content required specific to a Behavior Support Plan, which will assist in the efficacious provision of Positive Behavior Supports.
Scope: DDD HCBS Waiver Service Providers, Support Coordinator Services, ADMH-DDD Central/Regional Offices

Definitions:

Behavior Support Plan, also referred to as a BSP is a plan that assists an individual in building positive behaviors to replace or reduce challenging/dangerous behavior(s).

Behavior- defined as any observable and measurable act of an individual, bad or good.

Target behavior- defined as the undesirable or maladaptive behavior to be changed. The target behavior should be defined in specific and objective terms.

Functional Behavior Assessment- an assessment that identifies observable and measurable, operationally-defined behaviors of concern; identifies events and situations which predict when the target behavior will and will not occur; and identifies what functions the behaviors appear to serve as well as outlines replacement behaviors.
Procedures:
1. The Behavioral Services Procedural Guidelines require that, for any person exhibiting behaviors that interfere with the implementation of the Person-Centered Plan, a BSP must be designed and implemented to:

a. Reduce those undesirable behaviors

b. Describe needed alterations to the environment to reduce or remove triggers to undesirable behaviors

c. Describe procedures to promote and encourage existing desirable behaviors

d. Teach new acceptable behaviors that are effective to obtain desired outcomes for the person involved

e. Describe procedures to be used by staff to respond to dangerous or undesired behaviors when they occur

2. The BSP should provide clear descriptions of behaviors of concern and explicit instructions to staff on the actions they are to take to provide training, reinforce desired behaviors, modify the environment, respond to target behaviors, and tabulate data. A copy of the data sheet(s) to be used in carrying out the BSP should be included as part of the instructions for the BSP.

3. The BSP consists not only of the written plan but also its implementation.

4. There should be evidence of staff training and competence in carrying out the BSP.

5. Implementation of the BSP must demonstrate adequacy of the measurement method, including tabulation on forms that promote accuracy in recording and guidance to staff regarding the procedures used to count behaviors. A copy of the data sheets used in carrying out the BSP should be included as part of the instructions for BSP. The data recording form is considered a component of the BSP, and training in its use is a part of the implementation.

6. During implementation of the BSP, decisions regarding treatment effectiveness and the need for changes in treatment are made. Data must be presented and be adequate to justify the inferences drawn from them.

7. **CONTENT**- The BSP must include:

a. Demographic and operational information

i. Name, date of birth, and age of the individual

ii. Author(s) of the plan and supervising BCBA if applicable

iii. Date of implementation of the plan

iv. Restriction level of the plan and listing of all restrictions

b. The goal or purpose of the BSP (e.g., reduce hitting of others, running away from staff, and refusing medications; teach requesting reinforcers, waiting in line at store check-out, brushing teeth)

c. Historical information

Information relevant to current behaviors, including prior behavioral strategies and their outcome. Include prior restrictive interventions if applicable.

d. Diagnostic information

All diagnoses, psychiatric, cognitive, and medical (e.g., autism, ID, anxiety, genetic disorders, etc.)

e. Medications

Psychotropic and non-psychotropic medications with name of medication, dosage, and associated diagnosis and symptoms

f. Target Behaviors

i. Define each behavior of concern in terms that can be recognized when they occur

ii. If applicable, describe observable behaviors that indicate a psychiatric event is occurring (e.g., staring into a dark corner and speaking to the corner) and the method(s) for counting them when they happen.

iii. Include 12 months of data if available; specify type of data collection (e.g., average number of occurrences per hour, graphed by average per day; daily average number of 15-minute intervals within which the behavior occurred, etc)

g. A summary of the Functional Behavior Assessment, the hypothesized functions of target behaviors, and strategies to deal with them. List the source of information (direct observation, staff interview), describe settings, antecedents of behaviors, and maintaining factors.

h. Behavioral goals: Describe measurable goals for learning desirable behaviors and methods to be used to teach them and measurable goals and teaching strategies for reduction of undesirable behaviors.

i. Descriptions of antecedent modifications. Strategies that include reinforcement, changes to the environment, teaching of replacement behaviors, that make desired behaviors more likely and undesirable behaviors less likely.

ii. A description of the replacement goals for each targeted behavior.

iii. Specific procedures for staff to follow when target behaviors and crisis situations occur.

i. The supports needed to implement the procedures outlined.

j. Listing of all restrictive procedures:

i. Name of the procedure

ii. Level of restriction

iii. Justification for inclusion in the BSP

vi. Brief description of previous and current efforts to fade restrictive interventions

k. Data collection methods and monitoring of the plan

i. How staff will collect data both for target behaviors and for training

ii. Who will monitor the plan and when

l. Methods for staff competency training and monitoring of program implementation

m. Due process safeguards. Signatures of:

i. Individual served

ii. Guardian (if applicable)

iii. Plan author

iv. BCBA supervising the Plan

v. BPRC review and approval

vi. HRC Review and approval

8.3.c. Assistive Technology & Virtual Service Guidance via Appendix K/PHE2020

Responsible Office: Waiver Service Guidance
Reference: DDD HCBS Waivers
Effective: July 22, 2020
Revised: March 5, 2021

Statement: Assistive Technology and Virtual Services waivers per the COVID-19 Appendix K

Purpose/Intent: To provide guidance for accessing Assistive Technology and delivering virtual Services during the PHE/Appendix K waiver

Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central Regional Offices; Self-directed Services

Procedure:

Assistive Technology

1. Through the effective period of the Appendix K, verbal orders are allowed in lieu of prescriptions for Assistive Technology.
2. The recommendation for Assistive Technology **must be documented in the PCP** and **must** include the following:
    a. Who made the recommendation
    b. Why the recommendation was requested/needed
        i. If a Service Coordinator identifies that assistive technology is needed to enable an individual to communicate with those outside their home or residence, they should complete the following steps:
        ii. Discuss with the individual and their team, as appropriate, if the addition of assistive technology would meet this need
        iii. If the individual agrees that the addition of assistive technology would meet this need, then,
        iv. the Support Coordinator (SC) must work with the individual to identify and document the most cost-effective means of meeting this need in the Person-Centered Plan or Progress notes.
            1. Examples include:
            - A webcam for individuals who already have adequate access to a computer or laptop that meets their needs.
            - A tablet or laptop with built-in camera for those without adequate access to appropriate technology that meets their needs.
        v. SC then adds the service to the POC/PCP documenting why the assistive technology is the most cost-effective option selected
            1. The SC must ensure there is a plan for the person to access connectivity (explore internet providers that may be offering free WiFi or cellular internet access)
            2. The SC should assist in the development of an agreement for use of WiFi or internet if connectivity will occur utilizing the provider or family's system.
            3. The SC must identify if there are risks associated with using assistive technology and if so, address the risks with the PCP Team by updating the Risk Management Plan.
            4. The SC must determine whether individuals need support to set up or use the technology and create a plan for this support in the PCP.
            5. The SC must verify the agreed upon device was purchased and monitor the individual's progress towards the outcomes identified in the PCP.

Virtual Services

The Appendix K allows for an electronic method of service delivery (e.g., telephonic, virtual (like zoom), etc.). Services include Case management, Personal care that only requires verbal cueing, Day services, and monthly monitoring. Behavior Support Professionals, Nurses, and Occupational, Physical and Speech/Language Therapists may also provide electronic services in the home. Services should be documented in the person-centered plan and include why there is a need for electronic services (COVID-19) as opposed to the direct service that is traditionally provided.

NOTE: Virtual Services are intended to be used only in situations where in-person services are not advisable due to potential risk of exposure to COVID-19 and, therefore, should not be the first option for services.

8.5. Memorandum of Agreements (MOA) for non-contracted HCBS Waiver Services

Responsible Office: Waiver Service Guidance
Reference: DDD HCBS Waivers
Effective: November 1, 2020
Revised: March 5, 2021

Statement: Access to HCBS waiver services outside contracted provider network
Purpose/Intent: To establish a process to ensure access to HCBS waiver services when providers of those services are outside the contracted provider network and also, to ensure individual choice of vendors. (Examples may include the following: Environmental Accessibly Modifications, Personal Emergency Response System, Occupational, Speech and Physical Therapies). The MOA, if approved by the Associate Commissioner, can also be used for other services temporarily or until a contract can be fully executed depending on the type of service and identified need.
Scope: DDD HCBS Waiver Service Providers; Support Coordinator Services; ADMH-DDD Central/Regional Offices
Definitions:
Procedures:

1. The Support Coordinator determines through Person Centered Planning or other means (physician's recommendation, interdisciplinary team meeting, etc.) whether the service may be needed and/or beneficial to the waiver participant.
2. The Support Coordinator ensures the request goes through the RFA process for approval and ensures supporting information is included in the request.
3. If the service is determined needed/beneficial and is approved by the Regional Office after review of supporting documentation, the Support Coordinator and Regional Office will work together to identify a provider of identified service.
4. The Regional Office CSD will ensure the provider meets waiver provider qualifications and can provide services as described in the Scope of Service (or waiver service description) then submits a request that includes vendor information to the Central Office for approval to execute an MOA.
5. If approved, the Central Office ensures the provider is registered in STAARS then develops the MOA and the vendor is added to a provider list.
6. Once the vendor is chosen, the vendor submits an invoice to the DD CO Fiscal Office for processing payment.
7. The DD CO Fiscal Office will process the Medicaid waiver claims billing and pay provider once Medicaid payment is received.
8. This provider list will be maintained and updated in the Regional Offices for future reference.
9. Expired MOAs must be renewed to remain on the Vendor List.
10. Regional Offices should ensure updated vendor lists are provided to Support Coordination agencies in their region.